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Original Lectures.

THE GENERAL THORACIC CLINIC.

A CLINICAL LECTURE DELIVERED AT HAHNEMANN MEDICAL COLLEGE AND HOSPITAL OF CHICAGO, FEBRUARY, 1897. BY PROF. B. S. ARNULPHY, A. M., M. D.

We have to-day a few interesting cases to bring before you. The first is one of

AORTIC STENOSIS.—Here is a man (Case 19,801) who comes to us with a short and plain history. About three or four years ago he began noticing shortness of breath upon exertion. Later on he developed a pain under the sternum, which grew worse when he kept at work or was in a hurry; from time to time there is bleeding at the nose. He complains of a feeling of nervousness, and his digestive powers have become deficient. It is clear to see that he is quite worried over his condition. His family history is confused and indefinite.

Now, if we take a look at his chest, we are at first struck by a peculiar appearance around his epigastric region, extending over his liver; you see those spots of capillary and venous dilatation. They are the sign of venous stasis in the epigastric veins; they speak of heightened venous tension, and we know that such a condition goes hand in hand with diminished arterial tension, itself mainly dependent upon failure of ventricular action.

Here is another sign of capillary sluggishness; I pass my finger nail over the integument and you notice that the red streak thus produced persists for quite an appreciable time.

By percussion I make out an increased area of dullness over the præcordium, while by palpation I ascertain that the apex beat, itself radically lacking in systolic energy, is displaced downward and to the left. The weak and diffused character of the impulse bespeaks ventricular dilatation, not hypertrophy.

Now, I perceive over the aortic region a loud, widespread systolic murmur; I note that the second sound over the aortic valves is almost inaudible. Whence comes that obliteration of the aortic recoil? I can only think of one reason for it, and that is the lack of ventricular force. Still that left ventricle has stamina enough to put forth a systolic murmur that can be heard over the whole chest, even posteriorly. There may be some peculiar condition of the orifice to account for the production of such a loud murmur. You understand very well of course that the loudness of an organic murmur is not a bad thing in itself. In fact, in a case like this a lessening of the murmur would acquire the worst possible significance.

His pulse is small, which is no more than right, considering the obstruction at the aortic orifice, but it is neither wiry nor incompressible as it should be if the left ventricle were up to par.

Therefore the diagnosis is just as plain as can be, and reads thus: *Aortic stenosis*, with threatened loss of compensation and ventricular dilatation.

This patient should be put to bed, and on a milk diet, so as to relieve both the heart and the kidneys. The bowels ought to be kept free. Digitalis is not quite indicated, inasmuch as there is no disruption of the cardiac rhythm yet. I feel that the above measures, if they be adopted, with the help afforded the heart by arsen. strych. 3x two grains four times a day, will prove sufficient to rally the failing compensation.

ABSCESS OF THE LIVER EMPTIED THROUGH THE BRONCHIAL TUBES; SECONDARY TUBERCULAR INFECTION OF THE LUNG.—*Case 19,823.* This case is referred to our clinic by Dr. Cornelia S. Stettler. It presents for our consideration points of unusual interest, to which I am glad to be able to draw your attention. I will give the history in the doctor's own language:

This patient, Michael K., æt. forty-nine, was first taken ill the latter part of 1895. He began with severe pain in the right hypochondriac region, which grew rapidly worse from day to day and led finally to his coming home and falling under my care. Upon my first examination I found the temperature to be 103° and the pulse 120. He had no appetite, and complained of severe pain in the region of the liver, *extending to the right shoulder blade*, with extreme tenderness to pressure all about the organ, which was greatly enlarged. The bowels were constipated; the urine was free, but loaded with phosphates and urates. Hot applications relieved the pain somewhat, but it did not disappear altogether until there was a free purulent expectoration, which began two weeks later. The quantity expectorated each twenty-four hours was between *two and three quarts*, and of the most offensive odor. Septic symptoms manifested themselves at this time, and a fatal termination seemed inevitable. The skin became bronzed; the pulse ranged between 130 and 148, the temperature fluctuating between 103° in the morning and 104° or 105° in the evening; delirium was constant; the respiration was 30 and 35 per minute; the urine scanty; the bowels torpid.

The treatment consisted mainly of laxatives for the bowels, diuretics to stimulate the kidneys, and whiskey and quinine to antidote the effects of blood poisoning. This I kept up for two weeks, when all the symptoms finally abated and I was able to abandon the emergency treatment, and to depend upon remedies to take hold, which they did, but very slowly. At the end of three months he was able to sit up, and after another month could get about the house; and afterward, when the weather was settled, he got out of doors, the first time *in five months*. During his illness he lost seventy-six pounds. Within the two following months he regained all of forty pounds, *but now he is losing again.* He coughs and raises a great deal, his appetite is failing and he is losing ground generally.

This history speaks for itself. It is clear and to the point. And it is much to the doctor's credit that her patient should be able to stand before us to-day. This man is a baker by trade. Whether he sustained any traumatic injury of the liver or not, through a strain or otherwise, we cannot decide; but we find here the trail of a syphilitic taint contracted long ago. This etiological factor cannot be neglected. Besides, we are reminded by the doctor that twelve years ago he had an abscess on the sternum which broke out and discharged freely. Moreover, the father and two sisters of the patient appear to have died of pulmonary tuberculosis. Whether there has been a mixed infection of the liver or not in this case I cannot tell, but there evidently was sufficient ground for the development of an hepatic abscess. The symptoms of an acute hepatitis are very apparent from the previous history. No doubt there also was at one time fluctuation over the hepatic region prior to the voiding of the abscess. How did the abscess relieve itself? Via the bronchial tubes evidently, after having bored its way through the diaphragm, the two layers of the pleura, which must have been adherent, and through the tissues of the lower lobe of the right lung. Is this a common occurrence? Not by any means. You read of such cases in the text-books, but it seldom falls to the lot of a practitioner to see and examine them.

The question now arises, What is the present condition of the patient, and what are his chances of life? Look at his chest. It is decidedly flattened and contracted on the right side; the expansion on that side is sadly limited; upon percussion we have no difficulty in outlining a broad zone of dullness over the lower half of the right lung, where upon auscultation a few creaking sounds, evidently due to pleuritic adhesions, are discernible. The upper areas of the lung exhibit an indistinct broncho-vesicular breathing. While I can discover no distinct zone of infiltration or of softening, it is only too apparent that this lung, bound down by adhesions on every side, and infected

as it must have been, is in a very bad way. In my opinion it is doomed.

The patient has been a few days in the Hahnemann Hospital under observation. He coughs and raises a great deal yet. The hectic curve of his temperature is undeniable. He has night sweats, and is very susceptible to the slightest drafts of cold air.

The prognosis is bad, though he may survive for quite a few months yet. He would survive longer if his tuberculosis were to affect the fibroid type. We will give him *tuberculinum* 30x and silicea 30x in alternation, and watch developments.

FATTY DEGENERATION OF THE HEART.—*Case 19,815.* I will now present to you a typical case of fatty degeneration of the heart. This man, L. H. A., is forty-five years old. He is a merchant and comes to us for relief, referred to our clinic by Prof. Halbert. He complains of a fluttering sensation at the heart, accompanied by a pain which starts in the occipital region and travels down the spine to the lumbar region. There is also a painful feeling at the lower end of the sternum. Here now is a symptom of great importance: *faintness and dyspnœa upon the least exertion.* You notice that the patient is obese. Well, he says, that obesity is a common thing in his family. His father was very fleshy, and dropped dead in the street. All this is very significant.

Now, upon percussion we find an enlarged cardiac area of dullness; there is also a dilated stomach, somewhat encroaching upon the heart territory. By palpation I make out a diminished apex impulse. Auscultation reveals a slight systolic murmur over the aortic area, which is conveyed along the aortic arch. The question is: is this murmur due to an orificial lesion or to an abnormal condition of the aortic coats, or is it simply functional? Let us resort to the test of bimanual pressure. I press the upper part of the chest between my hands with great moderation, of course, as sometimes the test is ill borne by susceptible subjects. It arouses an unpleasant feeling in

the head with dizziness. We need no more to learn that there is some chronic aortitis present. This is the cause of the systolic murmur over the arch. Now, I auscultate the heart. The first sound is muffled, distant, somewhat prolonged, with a tinge of reduplication. The second sound is dry, clapping, weak. The heart beats at the rate of fifty-five per minute. Let us study the pulse. It runs at a quicker pace than the heart, a curious discrepancy quite characteristic of fatty degeneration of the ventricular walls. The reduplication is also indicative of degeneration, in fact it is a very early sign, and quite a valuable one when it is possible to exclude neurotic conditions.

I will now make another test. I suddenly raise the patient's left arm, while my fingers are on the radial artery, and I perceive that the pulse wave collapses and becomes almost imperceptible. This is a good sign of ventricular weakness, which in cases like this one means fatty degeneration.

There is one point in the patient's family history which I would like to call your attention to. I mean the fact that his father dropped dead on the street. What was the immediate cause of death? Was it apoplexy? Such may be the case assuredly. Obese people are liable to accidents of that kind. But it may have been something else. Persons affected with fatty degeneration of the heart are subject to peculiar pseudo-apoplectic attacks, they are are seen to suddenly lose consciousness and fall. The spell may only last one or a few minutes, and the patient generally recovers rapidly therefrom, feels well again and goes about his business as if nothing untoward had happened. As a rule these attacks become more and more frequent and prolonged and are followed after a time by signs of paresis. Loss of memory becomes then a prominent feature of the trouble. The speech also becomes hesitating, stuttering. Not infrequently the patients go off in one of those spells. Such may have been the case with our patient's father. Death may also result from sudden failure of the heart.

From all the signs and symptoms and facts we have gathered and reviewed, we are now enabled to form a synthetic, comprehensive view of the case, giving due regard to each fact according to the clinical hierarchy of its importance. In the background we find two general pathological conditions, viz.: *obesity* and *arterio-sclerosis.* Now, we know that both of these conditions are the differentiated expression of a common morbid process, namely, *arthritism*, a morbid modification of the system which includes in its vast sweep of influence such diseases as diabetes, renal and biliary lithiasis, gout, rheumatism, lithæmia, etc., etc.

Back of the history of obesity which runs all through the family of our patient, we would undoubtedly unearth, by patient inquiry a few of the affections just mentioned. Such has been my constant, uniform experience. All these diseases are after all the result of an all-pervading, insidious morbid influence. I mean "the slackening of nutrition," or "retarded nutrition." Hence the extreme importance of the systematic study of the diseases pertaining to that class.

As a result of this fatty process here instituted by hereditary influence, and promoted no doubt by the sclerotic lesion of the aorta, and possibly of the coronaries, we have here a heart whose myocardium is no doubt partly degenerated, while a good deal of fatty infiltration is also present. This fatty overgrowth must be considered as a mechanical hindrance to the heart's action. To these combined influences is due the symptoms: *faintness* and *dyspnœa upon the least exertion.* Considering that all the pathogenic conditions for the appearance of angina pectoris are here realized, we should be prepared for an outburst of the dreaded affection at any time.

The correct diagnosis should read thus: *General obesity, chronic aortitis, fatty infiltration of the myocardium combined with fatty degeneration, and moderate dilatation of both ventricles.*

The urine of this patient has been examined by Dr.

Croftan, who furnishes the following data: Total quantity in twenty-four hours: 1,100 c.c.; specific gravity, 1,018. No sugar. No casts. A little albumen.

The prognosis is not, cannot be favorable under such circumstances. We can only afford relief to the distressing symptoms, and perhaps retard the end a trifle. But the chances are the patient will die suddenly at any time, just as his father did. We will give him: Strychnia arsen. 3x and phosphorus 30x. The patient reported several weeks later, very much improved in every way.

THE PATHOGENESIS OF LYCOPODIUM CLAVATUM.

By CHAS. H. EVANS, M. D., ADJUNCT PROFESSOR OF MATERIA MEDICA AND THE INSTITUTES OF MEDICINE IN HAHNEMANN MEDICAL COLLEGE, CHICAGO.

The word lycopodium is derived from two Greek words signifying a wolf's foot, from a fancied resemblance to the footprints of this animal. Other names have been bestowed upon this plant, such as vegetable sulphur, club moss, stag's horn, wolf's claw and ground pine, all of these having for their origin certain real or supposed likenesses to the objects named. Witchs' meal was at one time a popular name applied to the granular powder or sporules, on account of its behavior like a liquid when allowed to move in a vessel inclined from side to side as well as from the property it has of resisting the moisture of water. Lycopodium is a trailing plant, native in both hemispheres, whose creeping stem extending along the surface of the ground from two to six feet or more sends up vertical branches at tolerably regular intervals, and strikes single roots into the soil at varied distances. The short branches, a few inches in height, are similar in appearance to the stem, and consist of a single axis upon which the overlapping leaves are thickly set. The bright green leaves are long, narrow, shaped like a shoemaker's awl, and terminate in a curved, bristle-like tip. A member of the cryptogamic or flowerless plants, propagated by spores only, it sends up a peduncle from the female branches, expanding at the summit into the sporangia,

within whose bracts the spores or seeds are contained. These latter constitute a pale yellowish powder which is understood to be meant when the word lycopodium is used. The entire plant is a dwarfed representative, a survival in miniature, of the once numerous and stately club mosses of the devonian and carboniferous ages, amidst whose sombre forests and warm, misty, carbon-laden atmosphere they, in common with their fern cousins, attained the size of gigantic trees.

The powder or granular spores, seen under the microscope to consist of honeycombed pyramidal grains, is employed in pharmacy in preventing newly made pills, lozenges, etc., from sticking together. When blown into a flame or thrown upon glowing coals it burns in a single swift flash, and for this reason was at one time used in the production of stage lightning; it also enters into the composition of fireworks. In the nursery it is extensively used for the purpose of drying the excoriated cervical, axillary, inguinal and gluteal surfaces of infants.

The medicinal virtues of lycopodium received scant recognition until developed by the Hahnemannian method of proving, still glimpses of its therapeutic value were obtained at one time and another in an empiric way, though they were afterward forgotten. It is interesting to note, however, that the maladies in which it has been known to be curative are the same that lycopodium invariably produces; another of the many instances of an unconscious practice of homœopathy. A species of lycopodium was at one time employed by the ancient Druids for "obstructions," etc., but its therapeutic uses were obscured by associated superstitions. Arnold at Heidelberg reported that an increase in the amount of urine followed the use of lycopodium in dropsy, especially when the latter was attended by scanty secretion of the urine. Martin, of Jena, in association with six others experimenting with it found it to produce an increase of appetite, rapid circulation and frequent calls to urinate, the latter being attended with pain, and cloudy, sedimentary urine, sometimes mucous and bloody. At one time lycopodium was used by the dominant school in the treatment of diseases of the lungs and kidneys, and it was also classified as an antispasmodic and diuretic, all of these being exactly the disorders to which our provings point. Various species of the lycopodiaceæ are used for medical purposes in the East and West Indies and South America as emetics, diuretics and purgatives, one variety causing

convulsions. In the majority of instances the stem and leaves were the parts employed, made into tincture or decoction, although the spores were occasionally used in Europe nearly three hundred years ago. In the early part of the present century it was discovered that when the powder or sporules of lycopodium were submitted to trituration with sand a fixed oil was yielded to the amount of 47 per cent. The medicinal properties of the plant reside in the highest degree in this oil, but as the envelope of the containing spores is exceedingly tough, considerable and long continued force is necessary to rupture this in order that the oil may escape. This necessary result is obtained in homœopathic pharmacy by means of trituration with granulated sugar of milk, the hard and angular crystals of which are capable of effecting the desired comminution, but in order to determine that this object has been fully attained the first trituration should be submitted to the microscope for evidence of its thorough accomplishment before succeeding triturations are attempted. The tincture is made from the first trituration by adding sufficient alcohol to make a pasty mass, and one part of this added to five parts by weight of alcohol; although this is called a tincture its drug power is but one-tenth, equivalent to the 1x dilution. Successive triturations are prepared from the first one by the usual methods.

The medicinal effect of lycopodium, as evidenced by our provings and their clinical counterpart, consists in the initiation of a condition of atony in which all the tissues of the body participate, a slow and continuous decay in function, a process of pathology rather than immediate organic change, although profound destruction of tissue and organ is the final result of a long and progressive series of trophic changes. Consequently this drug is not adapted *per se* to acute diseases, but is only applicable to sub-acute and chronic disorders. In exceptional cases when it is indicated in the first stages of disease it will be found that the latter has supervened upon previously existing lycopodium ailments which are still present and call for this remedy. The venous side of the circulation is that upon which the action of this remedy is especially exerted, and the sluggish current through the venous capillaries is apparent in the symptomatology of this drug, and not only in disordered function but in actual varicosis. This latter is especially noticeable in the superficial veins of the lower extremities and in other situations. The hæmorrhoidal

veins are the seat of varicosis and they are very greatly enlarged, contain a large amount of blood and bleed very freely. It is very evident from this venous engorgement, together with the similarly congested liver, that the portal veins are largely distended even to their remotest capillaries. Chronic or venous congestion is present in greater or less degree in all parts of the body, and many pathogenetic symptoms are plainly traceable to this source. Prominent among these is the desire on the part of the individual to be in the open air, as he finds general relief when so situated; this symptom is due to an unconscious necessity for greater oxidization of the blood through the pulmonary capillaries, although such persons are at the same time susceptible to cold and become chilly in an ordinary temperature. This condition, it is almost needless to state, is also met with in the pathogenesis of such agents as sulphur and pulsatilla, both of these drugs influencing the venous side of the circulatory system and presenting the same necessity for fresh air either through open doors and windows or outside the house, while experiencing a similar susceptibility to cold upon exposure. Periodicity is another characteristic of lycopodium and the return or aggravation of sufferings falls, in the majority, between the hours of 4 and 8 P. M., sometimes with a slight margin of extension at both extremes. Still another characteristic of this drug is the tendency of all complaints to commence on the right side of the body, and after continuing in this situation for a longer or shorter time to pass over and involve the left side of the body or corresponding organ when these are bilateral. The pains caused by this remedy are sticking in character. The specific malnutrition to which lycopodium gives rise, results in emaciation often to an extreme degree, and the grayish-yellow face is not infrequently seamed and prematurely aged. Functional derangement with subsequent enlargement is the fate of glandular structure under the influence of this drug; every group participating—cervical, tonsillar, axillar, inguinal, mesenteric and gastro-intestinal. In consequence of the involvement of the latter, dyspeptic symptoms are at once numerous and characteristic of this remedy; craving hunger for food that does not satisfy when eaten, or hunger for which a few mouthfuls are amply sufficient. Such persons seem actually to want food, but a small quantity fills them to repletion, "full up to the throat," as it is sometimes expressed, a sense as if the stomach was already

filled with food and the additional morsels were more than sufficient. On the other hand the appetite may be entirely lost and every attempt to eat is attended with repulsion for the food—"it goes against him," as it is said—and this disgust may be so great that it ends in gagging or even vomiting. In all cases slow and imperfect digestion is the rule with all its resulting accompaniments, such as acid stomach, heartburn, sour or bitter taste and distention of the stomach, rising of gas, together with a sense of weight and pain shortly after eating, etc.

Intestinal digestion is just as imperfect and fermentative changes in this region are constantly taking place, attended with an excessive formation of gas. As if this latter were not sufficient in itself, the venous radicles permit the passage of carbonic acid through their walls into the intestine contributing literally to swell the volume of gas and the abdominal cavity. Incessant shifting of this flatus causes an almost continuous rolling and rumbling, gurgling and croaking within the abdomen. Occasionally the gas manifests a tendency to accumulate in the hypochondria causing a feeling of pressure in this direction not infrequently extending around backward beneath the ribs, though this is more apt to occur in the left hypochondrium on account of lesser resistance in that situation, and gurgling and bubbling is often experienced in this locality.

Clinically this form of catarrhal enteritis is occasionally observed in infants and young children who have largely been fed upon farinaceous food or a dietary consisting chiefly of crackers and milk, or a morbid appetite has been fostered in this class of subjects for sweet articles, pastry in varied forms and delicacies of all descriptions to the exclusion of the proper amount of healthful food, in whom lycopodium has proved curative when associated with proper restraint in diet. The same result often obtains in adults who have subsisted for a long time upon a heavy and monotonous regimen.

The atonic effect of lycopodium is still further shown in the production of constipation, the enfeebled rectum being only able to expel the feces with the strongest aid and effort. The sufferer is obliged to exert himself to the utmost, straining downward with all his power, so much so that stitching pain is experienced in the temples with ringing sounds in the ears. Accompanying this voluntary tenesmus, intensely severe, sticking pain is felt in the rectum, which continues unabated long after the stool has been expelled;

the rectum is spasmodically protruded and the hemorrhoidal veins bleed freely. The greatest exhaustion then follows, a state almost bordering on syncope, from which the person recovers only after a considerable length of time. Diarrhœa is of infrequent occurrence although there are a certain number of cases in whom chronic intestinal catarrh exists that discharge thin, brown feces with undigested lumps, or pass thin, yellow and even purulent stools; occasionally the diarrhœa assumes a dysenteric character.

The massive enlargement of the entire abdomen, whether this is due to flatus or serum, is in striking contrast to the emaciation presented by the body and extremities above the waist line. The liver is affected both in structure and circulation, and many symptoms are presented by this viscus, both local and remote; it is sensitive to touch, and experiences various painful sensations, and may be subject to severe tensive pain. Flatus becomes incarcerated beneath its inferior surface, and causes pain from the upward pressure. That the biliary function is also impaired is recognized in imperfect depuration of the blood and in the jaundiced hue of the skin. Diseases of the liver to which lycopodium is adapted are slow in progress, but terminate at length in profound structural alteration; chronic hepatic diseases of varied form and nature are within the curative sphere of this remedy, and even cirrhosis with its attendant dropsy has been mitigated by it when the associated symptoms indicated the use of this drug.

The uric acid diathesis established by lycopodium is an example of the power possessed by drugs of instituting a specific succession of events having a definite relationship. The pathological connection between the digestive and urinary systems and the lithæmic process is identical, whether initiated by natural or artificial disease; and in the production of this diathesis lycopodium is a conspicuous agent. The urine is loaded with uric acid, which is deposited in the receiving vessel in fine sand-like crystals shortly after its passage, and when the urine has been allowed to stand for some time, a copious "brick dust" sediment is precipitated. When the subject of the lycopodium diathesis is in an unconscious (typhoid) state, and the urine is passed on the sheet upon which the patient lies, this same pink or reddish sand may be observed, and the same occurrence takes place upon the diaper of

infants. The passage of urine is preceded by an intense pain in the back, "terrific," as it has sometimes been designated; but relief instantly follows the flow. In infants the same thing evidently takes place, for they are noticed to scream violently just previous to urinating, after which they seem entirely relieved. The flow is clear, watery and quite free in quantity, although at times it may be scanty, dark or bloody, or long clots of blood are discharged. Coarse grains of "sand" are passed with the urine, and even small calculi may present themselves. The urine is retained, or may be suppressed. Involuntary discharge of urine may take place in the presence of an adynamic (typhoid) state, or nightly enuresis occurs in children. A chronic inflammation of the bladder sometimes exists, with frequent calls to urinate, burning in the urethra and discharge of mucous urine. Clinically, the state known as Bright's disease has received benefit from lycopodium when the characteristic symptoms of this drug were present.

The mouth under the influence of lycopodium shows a scorbutic condition in which the gums are swollen and bleeding, the teeth loosen in their sockets and are painful when masticating, the tongue covered with vesicles and ulcers, and free secretion of saliva. Morbid tastes are perceived, bitter, metallic, etc. A sensation is experienced as if a ball rose into the throat. Inflammation of the throat is manifest with frequent and painful efforts to swallow. The tonsils share in the inflammatory process and become greatly swollen, with this peculiarity that the one on the right side is the first of the two to be attacked. Enlargement of the tonsils is quite considerable and the pain and contraction in the throat very decided when swallowing; the follicles are swollen and when these break show round flat ulcers Occasionally the tonsilitis is so intense that suppuration takes place, and if this occurs in both tonsils the same order of succession from right to left is preserved. Attempts to drink result in the return of fluid through the nostrils.

Rheumatic pains in the muscles and in the joints are caused in great number by lycopodium, particularly in the articulations, and even those of the hands and fingers. In the last named situation it has proved of service in rheumatic gout when the joints were greatly enlarged and painful, showing a correspondence between lithæmia and lycopodium.

The nutrition of the skin is seriously impaired by the action of this drug. Brown spots or patches, the so-called "liver spots," appear on thorax, abdomen and thighs. In some persons lycopodium has caused a rough and scaly condition of the skin; sometimes the skin is covered with scurf and the surface of various parts of the body itches so intensely that it is scratched until "raw" and bleeding.

A fine, thickly-set papular rash occurs in various localities or spreads over the entire body. Patches of urticaria appear from time to time and are so persistent in their recurrence that it may be termed chronic. Acne is also equally obstinate. Excoriation of the skin is so frequently cured by this remedy that the benefit derived from its use in the nursery must evidently depend on the oil released from some of the spores when these were gathered. Vesicles and pustules arise and may proceed to suppuration with constant offensive discharge, drying into thick crusts and bleeding when scratched. Should this eczema manifest itself upon the scalp the cervical glands become enlarged. Large boils form and are of frequent recurrence under the influence of this remedy.

The respiratory organs are objects of much attention on the part of lycopodium, and this of the most serious character.

A sub-acute catarrhal inflammation of the air passages with or without parenchymatous pneumonia is manifest, attended with a copious secretion of mucus. Cough is almost constant, and although occasionally dry is usually accompanied with expectoration. The presence of mucus in the chest is very apparent, and rattling or wheezing is noticeable even during ordinary respiration. The same is also true during cough, the whole chest seems full of "loose" mucus, and yet a good deal of coughing is necessary in order to raise it, as it is quite tough and stringy. The expectoration is gray and granular, or it is yellow and thick or greenish or bloody. One prover had cough and purulent expectoration attended with night sweats, until the drug was discontinued. Shortness of breath is complained of, dull aching pain or sense of pressure is felt in the chest with constriction of the thorax and stitching or sticking pains occur in the lungs.

Lycopodium has proved useful in cases of pneumonia that have recovered imperfectly or when it has occurred in tubercular or strumous subjects and advancing phthisis is suspected. Even when pulmonary consumption is fully

developed this remedy, in the light of its provings, will often afford palliation. A characteristic symptom of lycopodium in the course of acute (bronchial?) pneumonia is a fan-like motion of the nostrils. In dilatation of the bronchia (bronchiectasis) considerable relief is afforded and the same is true of its use in emphysema. The depressing influence of lycopodium is also observed in the brain, where it produces a state of cerebral anæmia. The emotional centres present an exceedingly irritable and fretful disposition or a sad and weeping mood is developed, or else profound despondency and melancholia enshroud the individual in the gloom of hypochondriasis. The intellectual faculties are also involved, and the person becomes easily confused whenever he makes an attempt to think or to converse; this is especially noticeable in his selection of wrong words or phrases when speaking or writing. Memory is greatly impaired and there is increasing mental torpor. This is an important remedy for those in whom softening of the brain is impending, persons who have been overworked mentally, have become weak and debilitated, and are the subjects of gastro-intestinal disorder. The motor nerve centres are also invaded by lycopodium and trembling of the extremities and of the tongue, twitchings in various parts of the body and even involuntary extension and contraction of muscles in periodic paroxysms all testify to its influence upon this tissue.

It also acts upon the thermogenic centres and has, in several provers, produced well marked attacks of ague, observing the characteristic hours of lycopodium; the chill recurred daily, commenced in the back, thence spreading over the body, with shivering, and was attended with nausea and vomiting and pain in the wrists, hands and fingers. It also has its place in the treatment of adynamic (typhoid) fever.

Clinical Society Transactions.

CORNELIA S. STETTLER, M. D., Corresponding Secretary.
ORRIN L. SMITH, M. D., Recording Secretary.

FEBRUARY MEETING, 1897.

The regular monthly meeting of this Society was held in the Amphitheatre of the Hahnemann Medical College at 8:30 P. M., on Saturday, February 27, 1897, President Shears in the chair. The attendance was unusually large.

REPORT OF THE SECTION ON GYNÆCOLOGICAL SURGERY.

R. LUDLAM, M. D., Chairman.

XI. Tubo-abdominal pregnancy; operation; recovery. By Dr. E. S. Bailey.—*Case.* Mrs. A., age thirty-five years, American, mother of several children, was taken ill about January 24. Dr. Belle Eskridge, of this city, was called. The patient's condition seemed to be that of impending miscarriage. The pregnancy supposed to be the second month, possibly a little more. The peculiar location of the pain and the peculiar character of the pain, led to a very early suspicion of ectopic pregnancy. For four weeks or more the patient had a hæmorrhagic uterine discharge. For four days prior to January 31, there were laborlike pains. Suddenly on this date the pains stopped and a large hard mass was soon discovered by the vaginal examination in the Douglas cul-de-sac. Dr. Eskridge telephoned February 4, that she had a patient with extrauterine pregnancy, needing surgical attention. February 5, the patient was thoroughly examined at the Hahnemann Hospital and the diagnosis of hæmatocele confirmed and an operation was decided upon. For six days the patient's condition had improved and, as there was no immediate haste, she was carefully watched and persistently nourished and stimulated. February 8, under careful preparation, the abdomen was opened. The long delay was due solely to the condition of the patient. I have never seen such extreme emaciation, except in fever cases. The bones of the spine were distinguishable through the

abdominal walls and in the line of incision, through the abdomen, not one bit of fat was to be seen. Present at the operation were Drs. Eskridge, Clapp, Kahlke and others. The pelvis was filled with clotted blood which was carefully removed. The fœtus and sac being at the distal portion of the right fallopian tube. The sac had ruptured and its contents were extravasated into the peritoneal cavity. The tube, ovary, decidua and clot were lifted out of the pelvis, the mass ligated, the pelvis sponged, then irrigated, and two quarts of sterilized water left in the abdominal cavity. The abdomen was closed without drainage. The operation was short, the patient returned to her room in good condition. A rectal enema of saline solution of one quart was passed into the colon and retained. The patient made an uneventful recovery, no increase in temperature above 100°, and the pulse not above 110 at any time during convalescence. On February 20, she left the hospital by ambulance for her home; on the nineteenth day after the operation, the next house to her own was on fire, she got from her bed into her clothes unassisted and prepared to leave the house. At this date, February 27, she reports through her physician who discovered her true condition and faithfully administered to her through it all, that she is feeling splendidly.

Confirmation. The tubal pregnancy, the decidua, the hæmorrhage through the fallopian tube into the uterus, as evidenced by clots found in the uterine portion of the tube. The cessation of laborlike pain at the time of rupture of the sac and the formation of the hæmatocele. The decidua in the pelvis, the clots undergoing the softening at the time of the operation, the immediate improvements in cessation of the hæmorrhages and the very prompt recovery. Old adhesions were present at the ovarian and fimbriated tubal region, new adhesions had been forming out of the blood clot. The specimen is preserved.

XII. Some very rare cases of extra-uterine pregnancy. By Dr. R. Ludlam.—Within a very short time the clinical history of extra-uterine pregnancy has been pretty clearly established by the gynæcologist. Ten years ago we knew as little of it as the surgeons did of appendi-

citis. But now we have learned that it is really more frequent than it was supposed to be; and that, while some cases demand prompt surgical interference, others may safely be left to proper medical care and to the conservative powers of nature. In these respects, and also because the rare and exceptional forms of ectopic gestation are attracting most attention and are the most instructive, the lesion is the counterpart of appendicitis. During the past two years my own clinic has furnished the sub-classes four of these very exceptional cases; one in which tubal pregnancy occurred twice in the same subject, and in which I operated with full recovery of the patient twice within six months*; another and very desperate case, of thirty months' duration **; a third and a fourth of intra-parietal pregnancy. In private practice one of the most striking among my recent cases of this kind, and in which the patient was practically pulled out of the grave, is given in the last volume (XVII.) of the CLINIQUE, at p. 325. Another, which has not yet been published, beside being extremely rare, illustrates the benefit of conservative treatment when it can be based on reasonable grounds:

Case. Extra-uterine pregnancy with the placenta in utero and the fœtal sac within the Fallopian tube. The following history was furnished me by Dr. H. Parsons, of Ravenswood, with whom I saw the case in consultation:

July 17, 1896. Mrs. —— was attacked with very violent pain in the lower abdomen. She obtained relief in an hour or two without opiates. The 18th and 19th she was comfortable, except for severe soreness and tenderness not referred to one side more than the other.

On the 20th, 21st, 24th, 26th, 27th, 29th and 30th, she suffered from recurrence of most extreme pain, which required morphine to relieve it. She had menstruated six weeks before, and had at this time a vaginal discharge of an offensive, dark and watery character. There was no return of severe pain, but she had constant soreness and tenderness in the lower abdomen, accompanied with slight fever. The 9th of August she had a free hæmorrhage. I

*The CLINIQUE, Vol. XVI., p. 471, **Vol. XVI., p. 155, do., p. 568.

curetted and removed some *undoubted* placental tissue. After this all discharge ceased. The patient's general condition, however, did not improve as anticipated. The general health was much impaired, the soreness remained, nutrition was poor; she did not sleep well, had a rapid pulse and her temperature ranged from 99½° to 101½°.

I think it was the 20th of August, when a swelling was detected in the right pelvis. She was kept very quiet in bed, and since September 1, has been getting better. At this date, September 17, 1896, she has a normal pulse and temperature, sleeps and eats well, has no pain or soreness, and the tumor in the right pelvis has diminished considerably in size.

On August 23 I first saw the patient with her physician, Dr. Parsons, and we decided that, despite the evident tubal tumor, as her symptoms were improving and as there was no present emergency, it would be safest and best not to operate at that time, but to watch her very carefully and to await developments. The chief argument in my mind against immediate surgical interference was that since the placenta had been detached and removed from the uterine cavity, the fœtal sac and its contents must of necessity be reduced to the starvation point. Under these circumstances, therefore, and with no sign of hæmatocele, we might reasonably await the absorption and the final disposition of the tubal tumor without putting the patient to the risk of a laparotomy. The end justified the expectation, for early in October, after a four months' absence, the menses returned regularly and normally and the tubal growth steadily diminished in size and tenderness. I visited and examined the patient again November 2 and found her in excellent health, as well and active as ever, the tubal enlargement was scarcely perceptible and the cure had been spontaneous. Nearly seven months have now passed and there has been no further trouble.

Discussion: The President: I would like to ask Dr. Ludlam if he would feel warranted in operating in a case of suspected extra-uterine pregnancy in which he is unable to detect the presence of a pelvic tumor? I have

in my mind the case of a patient who, six weeks after her last menstruation, complained of sickness at the stomach, colicky pains and some tenderness over the uterus and left ovarian region. Three days later she again had an attack of nausea, severe pain in the left ovarian region, followed by tenderness all over the abdomen. One week after the second attack she was taken in a somewhat similar way, with great weakness, pallor and coldness of the extremities. From this attack it took nearly twenty-four hours to recover. There was a subsequent attack four days later, with pain in the left ovarian region, followed by nausea, movements of bowels, pronounced prostration, almost collapse, difficulty of breathing, feeling of suffocation, and followed the next day by tenderness all over the abdomen. There was no perceptible tumor. She finally recovered without an operation. Would these symptoms indicate extra-uterine pregnancy; would you feel warranted in making an operation, and do you think the patient might die in one of these attacks?

Dr. POPPE asked whether the vaginal method of operating in extra-uterine pregnancy was not the better one, and cited a case of his that drifted into an old-school hospital where this condition was said to be present, and the surgeon proposed to cure it by making a vaginal hysterectomy. He, Dr. Poppe, had however insisted that the case was one of pelvic abscess. A vaginal incision confirmed his own diagnosis and cured the case without removing the uterus.

Dr. SHEARS: I ran across a case of extra-uterine pregnancy some time ago, while in the country for the purpose of making an operation, which may prove interesting because it may raise a question as to the best method of reaching these misplaced products of conception. The patient had been ill for a long time and I was asked to see her because it was believed she was suffering from a pelvic abscess. She had daily chills with a temperature of 104°, was much emaciated and showed every evidence of blood poisoning. Examination showed a pronounced tumor in

the posterior vaginal cul-de-sac, and a careful survey of the early symptoms led me to believe that we had a case of extra-uterine pregnancy with suppuration and destruction of the fœtal material. The extreme condition of the woman led me to advise an immediate operation by the vaginal method and an incision was made over the most prominent portion of the tumor which disclosed a decomposed fœtus and placenta. These were promptly removed and the cavity thoroughly drained and the patient made a tedious but very satisfactory recovery. Dr. Ludlam will no doubt give us clear rules as to when the vaginal route should be preferred.

Dr. A. L. Blackwood expressed an especial interest in the subject because of some cases with which he had had to do.

Dr. C. F. Barker: Early in my practice, some fifteen years ago, I encountered a case of extra-uterine pregnancy in which the subjective symptoms were the only recognized evidence of the condition for more than four months. A prominent old-school physician of Boston was treating the case and regarded it as one of severe ovarian neuralgia. He was called away and the patient was then under my care for the next three months. During the first month of my attendance she had three of these attacks of pain but none afterward. The pain came on suddenly each time and was in the left ovarian region, a cutting, tearing sort of pain, radiating in all directions and evidently of the most excruciating character, the agony lasting from one to three hours before completely subsiding. During these attacks she was bathed in a cold sweat, and seemed at times about to collapse. The abdomen on the affected side remained very sore for several days, but there was no rise of temperature, and I could detect no signs of a tumor. The menstruation remained regular and natural, and after the third attack of pain she gradually became quite well, though rather weak for the next two months. At the end of that time owing to some difficulty in locomotion she consulted me again and I found the uterus somewhat

enlarged, the fundus inclining to her right side and a growth or enlargement in the left ovary or broad ligament. Upon being informed of her condition, her husband at once took her to New York, where she was operated upon. A fœtus was removed from the left broad ligament. She did not, however, survive the operation.

Dr. LUDLAM: As the result proved, the first case cited by Dr. Shears was one in which there was no justification for the use of the knife; but the second one did necessitate a vaginal section and the emptying and drainage of the intraligamentous fœtal sac. Dr. Poppe's question as to operating by the vaginal route is pertinent, for there are those who always prefer it. In some cases of ectopic gestation it certainly is best, but as a rule I prefer to make a laparotomy.

Should any one doubt the possibility of the placenta having been within the uterus and the fœtal cyst within the tube in the case that I have reported, the following quotation will answer for it: "In some cases a part of the ovum may be within the uterine cavity; thus, the placenta has been found inside the uterus, while the fœtus lay in the tube; or part of the child may be intra-uterine and part intra-tubal; or the placenta may be wholly situated in the tube, while the child is inside the uterus."* Its extreme rarity, however, carries with it the hint that the curette is not often called for, and may be very mischievious in extra-uterine pregnancy. For the removal of the decidua as it exists in most cases may have a very different effect from that of taking away the placental tissue, as was done by Dr. Parsons for his patient before my first visit.

XIII. A NEW METHOD OF LIGATING THE PEDICLE IN TUBO-OVARIOTOMY. By M. PIERRE DELBET.† TRANSLATED BY DR. R. LUDLAM, JR.—In the numerous varieties of treatment for salpingo-ovaritis the unfortunate fact is that in certain cases the pains persist after operation. Such cases are

*Abdominal Surgery, by J. Greig Smith, M. A., F. R. S. E., etc. Second edition, p. 313.

†Annales de Gynécologie, November, 1896.

rare, and while it is very exceptional to have the persistent pains in a severe form, there are those who continue to have the abdominal suffering.

What is the cause of these pains? The partisans of hysterectomy claim that it is the uterus. This is easy to say but difficult to prove, for the uterus is not an organ that is pathologically very sensitive. We frequently see those who are ill with a severe metritis and leucorrhœa, but who do not complain or suffer as long as the afflicted organ is in a normal position and the appendages are not implicated. Besides, we find that there are those who continue to suffer after extirpation of the uterus. These pains must therefore originate from other causes. It is claimed that such patients are nervous. There is some truth in this explanation, but it is too general. Doubtless there are nervous subjects who suffer without any apparent cause. Perhaps there are some others who have a neuritis which develops after surgical interference. But it must also be said that those who suffer after hysterectomy are often the very ones in whom the extirpation of the appendages has been incomplete.

I believe that the pains which persist after a laparotomy may be attributed to the following causes:

1. Constriction and drawing of the pedicles by the *en masse* ligatures.

2. A slight infection from the ligatures which is not violent enough to cause serious trouble, but is sufficient to cause the formation of exudates.

3. The non-removal of the uterine extremity of the tube. When the broad ligament is ligated *en masse* there is always a small stump of the tube in the ligatures, even if the ligatures are numerous and are interlocked.

4. Adhesion of the pedicles to the intestines or the bladder.

5. Displacements of the uterus.

Can all these causes for pain be avoided? I think so. It seems to me that the method by which laparotomies are made for salpingitis is still tinctured with the fear that was formerly supposed to exist when operating in serous cavities. Is it necessary to use such coarse threads for the ligatures *en masse*, and which draw upon the peritoneum and neighboring organs? Is the hæmorrhage so formidable? Only a few veins and two arteries, the utero ovarian and the extremity of the uterine, are severed: two arteries, the larger one of which is not half as big as the radial

artery. Why not do as is usual in other cases—dissect, divide, seize with forceps, and tie the vessels? This has now been my method for some months. After some blundering, the detail of which is not especially interesting, I arrived at the following technique: I always use a table with a slanting top, and without which this operation would be almost impossible. The adnexæ being liberated from their adhesions and drawn outside of the abdomen as usual, I proceed according to two different methods, adapting myself to the case. When the appendages are entirely free and not ruptured, and my hands are still aseptic, and when there is no septic surface to be handled, I pass an ordinary silk ligature with a blunt needle through the broad ligament near its external margin, so as to tie the utero-ovarian pedicle in a single loop. Then I cut the remaining portion of the broad ligament without any preliminary ligature, as I said previously.

On the contrary, when I must break up serous cysts which are held by peritoneal adhesions; when the tubes have ruptured; when my hands are soiled by their contents; and when the ligature is liable to touch these septic parts, I do not make any preliminary ligature, but at once cut the broad ligament with scissors. I begin on the outer side, while my assistant applies the forceps to the vessels as they are being severed. The utero-ovarian artery rarely bleeds from the pedicle. On the contrary, the stream of blood comes from the edge of the portion to be removed, which demonstrates that the circulation goes from the uterine toward the utero-ovarian artery. This invariably shows that the uterine artery is the artery of the appendages and of the uterus when it is empty. The utero-ovarian artery is only important during pregnancy. While this artery does not usually bleed during salpingectomy, I seize it, and place a second forceps on the large open veins that are found at the side of it.

I thoroughly examine the line of division to be sure that the entire ovary is removed, in order to avoid the bulb of this organ, and not to cut the same vessels several times. Proceeding thus generally no vessel will be found in the middle portion of the broad ligament. Then raising the margin of the ligament I approximate it to the tube, having respect for the round ligament, which is very valuable in making the hem that will finish the operation, and on reaching the angle of the uterus, I cut the uterine artery. This artery is only slightly adherent and can be easily

seized with forceps. It is sometimes divided into two branches, which are separately seized. Finally, I finish by cutting the tube; I might almost say the uterine cornua. Twice I had to hollow out this cornua because the intra-uterine portion of the tube was dilated and contained a caseous magma. The appendages thus removed and all vessels clamped, of which there are generally four or five, I then wash my hands if I have reason to believe that they have been soiled; I carefully cleanse all the parts, and I then cauterize the inner orifice of the tube and apply my ligatures.

There then remains a straight longitudinal wound extending from the uterine cornua to the superior strait, which I close with a hem-stitch. The round ligament is very useful to re-cover the internal surface of the wound. Each of the hem-stitches is passed after Lambert's method to obtain a good sero-serous apposition, so that there remains no raw surface, and that all ligatures may be hidden by the peritoneum.

This method of extirpation of the appendages represents all the advantages which I stated in the commencement of this paper:

1. It allows the entire removal of the tube without leaving the smallest stump, which is a very important consideration.

2. It prevents the dragging caused by the ligatures *en masse*, and the post-operative pains are almost nothing.

3. It prevents one real source of infection by ligatures, contact with septic hands or ruptured tube. Infection caused by ligatures might be a source of more or less serious trouble and persistent pains.

4. It lessens the extent of raw surface and thus limits the possibility of adhesions. After the ligature *en masse* there is frequently a pedicle of quite a size, which may be very large, and the raw surface of which is likely to contract adhesions.

The uterine appendages removed, it only remains to reposit the displaced uterus. For this I make an anterior abdominal hysteropexy, which operation I do systematically in every case of salpingectomy, having first perfected my technique, as can be found in the thesis of Chavin. I have performed this operation a number of times without the least discomfort to the patient afterward.

Discussion: Dr. Shears: The operation described is an ingenious one and there are many points contained

therein that commend themselves to the careful surgeon, and among them I would notice the method of closing in the surfaces which have been denuded of peritoneum. I have long felt that the method which leaves a large raw surface in the abdominal or pelvic cavity, subjects the patient to innumerable risks which the more careful measures detailed in the paper just read, might entirely prevent. I remember a case which came to me with symptoms of intestinal stricture, following an ovariotomy. The distress of the patient was so great that I felt warranted in opening the abdomen and found the whole trouble to be due to the adhesion of the intestines to the pedicle which, I believe, had been left denuded of its peritoneum and in a condition to readily adhere to anything with which it came in contact. I have no doubt but that the method herein described would prevent the occurrence of such adhesions.

Dr. R. LUDLAM SR. endorsed the points made in the paper, and had no doubt that the plan of separately tying off the few vessels that were cut in most cases of tubo-ovariotomy would have its advantages. He had thought that the late Dr. Beebe's method of resorting to torsion of the separate vessels might be safe and sufficient, after which the tissues could be tucked in and covered with peritoneum. In that case all foreign material would be excluded.

XIV. SYMPHYSIOTOMY. BY DR. SHELDON LEAVITT.*—This operation, which consists in division of the symphysis pubis for the purpose of amplifying the conjugate diameters of the pelvis in parturition, is a revival of what was long known as Sigault's operation. It was performed by Sigault in 1777, and, as the first result was favorable, operations by others soon followed; but, unfortunate experience, proceeding very likely from the imperfect methods of those days, so disheartened obstetricians that, for nearly a century. it fell into disuse. It was revived by Morrisani and Novi, of Naples, in 1866, but escaped general professional attention until some six years ago. To Pinard, of

*In Dr. Leavitt's unavoidable absence this paper was read by title and referred.

Paris, and Harris, of Philadelphia, we owe its final adoption as a commendable procedure.

Though driven out of obstetric practice as an approved operation, and banished for about a century, chiefly because of its high mortality, yet now, though it has been restored to obstetric favor for only a brief period, the operation has come to share so largely the benefits of clean surgery, that the maternal mortality associated with it has been steadily diminished, until in the hands of skillful operators, it has reached a point which compares favorably with that attending vaginal hysterectomy, and is said to be below that of amputation of the breast.

Dangers of the operation. The risk to life lies almost exclusively in the direction of sepsis, but, as we have good reason to believe that this danger is essentially under control of the operator, being determined by the tone and character of his procedure, one finds in these truths ground for the most profound encouragement. It is not surprising that the earlier series of operations disclosed a mortality percentage varying from 10 to 25, in view of the slovenly nature of ordinary obstetrical practice which then prevailed. As bearing upon the recent mortality statistics, we should remember that many of the operations have been performed by those who, though possessing much obstetrical skill, have yet lacked the surgical drill of gynæcologists or general surgeons. The fact is that obstetrical practice creates a strong demand for surgical skill, and should be pursued, as far as conditions will justify, as a special practice.

The operation of symphysiotomy does not necessitate the opening of any cavity, nor does it involve the exposure of important viscera, for which reason we believe that, when performed under proper precautions, upon a woman who has not been already subjected to profound exhaustion, to extensive contusion of pelvic structures or to the introduction of septic germs, it should be attended by the most happy results.

The chief thing which militates against a reduction of the maternal mortality of this operation to the figure acquired by parturition unattended by operative intervention, is the liability to preoperative infection growing out of inattention to antiseptic details by the accoucheur who may have had the case in charge. Even the casual observer will not fail to recognize the presence of certain factors in connection with the morbidity and mortality of

symphysiotomy, from which deliberate surgical procedure is oftener free. Obstetric practice is still carried on in the homes of our patients, where in the average case, strict asepsis can be neither obtained nor maintained. For this reason I insist that hospital cases should be regarded as the true expositors of the advantages of the operation. If this were the only drawback, we might hope for an excellent showing; but, unfortunately, the surgeon who performs the operation is not often the accoucheur who has had the labor in charge, while it is a well-recognized fact that such accoucheur, notwithstanding his knowledge of antiseptic methods, is often exceedingly untidy in his work, when viewed from the standpoint of neat surgery.

There was at first an expressed fear that the disastrous results of the operation would not be confined to maternal mortality, but would likewise involve the stability of union between the separated articular surfaces, and thereby compromise the woman's subsequent comfort and her ease of locomotion. But it appears from the reports which I have thus far been able to gather that the latter fear has no substantial basis in fact. It is true that preternatural mobility of the pubic bones may be protracted for weeks, or even months, but the desired result is almost surely, though sometimes tardily, obtained.

Advantages of the operation. The benefits of symphysiotomy are limited to those cases wherein there is so evident a disproportion between the cephalic and pelvic diameters as to preclude the possibility of safe delivery through resort to any ordinary expedient. The disproportion may not be learned until parturient efforts have continued for hours; but one ought not to await the disclosure of such discrepancy by the development of the phenomena incident to long-protracted, ineffectual efforts of both patient and accoucheur. A careful estimate of both pelvic and cephalic diameters ought always to be made at an early stage in parturition if the least suspicion of pelvic inadequacy arise in the accoucheur's mind. Besides, in studying a case of this nature it should be remembered that the estimate of possibilities is entitled to be markedly influenced by the state of cranial ossification which the examination discloses, inasmuch as it is possible for a fœtal head, not far advanced in ossification, to conform to relatively short pelvic diameters under the moulding influence of instrumental compression and traction. The force of this suggestion is seen, when in one case a safe delivery

with the forceps is made, while in another, with a head of the same relative diameters, we may be driven to performance of symphysiotomy, or the older, and almost discarded operation of craniotomy.

Accurate measurement of the pelvic diameters cannot be made, as we are provided with no mensural instruments capable of being satisfactorily applied on the inner surfaces of the pelvis, the reading of which will reveal the true dimensions of that bony basin. Intra-pelvic anatomy constitutes an insuperable obstacle to satisfactory attempts of this nature. Approximate dimensions only can be determined by any means at our command. They may be estimated with tolerable accuracy by means of instruments intended for external use, measurements being made between certain anatomical points, the most important of which are the anterior and posterior superior spines of the ilia, the upper border of the symphysis pubis and the spinal process of the last lumbar vertebræ, these being compared with the same measurements taken from what are unquestionably standard pelves.

The diagonal conjugate diameters are estimated by measuring from the posterior superior spine of the ilium on one side to the anterior superior spine of the opposite side. The conjugata vera can be approximated by placing one point of the pelvimeter on the symphysis and the other on the spine of the last lumbar vertebra. The latter diameter, however, can be determined with greater accuracy by internal measurement with the fingers. In making such an estimate the half hand is introduced until the point of the index finger rests on the promontory of the sacrum, the relation of the pubic arch to the hand being noted, and the distance subsequently measured. From this result nine-sixteenths of an inch should be deducted, the remainder representing the approximate diameter.

The benefits of symphysiotomy are adapted to cases which have hitherto called for craniotomy, and accordingly the former operation may be regarded as a rational substitute for the latter. Therefore, since symphysiotomy has come to be recognized as a legitimate obstetric procedure, it is fair to assume that craniotomy finds proper place in those cases only where fœtal life has become extinct. I assume this position with but little hesitancy in view of the record recently made for the former operation, though I am well aware that it may encourage the inexperienced and poorly qualified obstetrician occasionally to undertake sur-

gical work which he cannot perform in the most approved manner, for which reason it will be opposed by many. In extenuation of so bold an attitude we contend that embryotomy is often undertaken by the ordinary practitioner in response to professional as well as lay assumption that he is qualified for the work, though the statistics of such surgery disclose a mortality fully as great as that which awaits upon symphysiotomy from the hands of the same practitioner.

I clearly recall the opinion concerning symphysiotomy entertained by obstetricians only a decade ago, which was in substance, that separation of the pubic bones would not materially increase the particular diameters of the pelvis upon which more especial demand is made in dystocia due to pelvic contraction. Later investigation has shown the fallacy of the claim.

The truth is that the conjugata vera may thus be increased from one-fourth to one-half an inch, while the transverse and oblique diameters are increased from three-quarters of an inch to a full inch; from which observation, so often clinically verified, we may safely infer that the operation may be undertaken with good hope of success in the flat pelvis, when the true conjugate diameter is reduced as low as two and three-fourths inches, provided the fœtal head appear to be rather below standard dimensions; but, in the equably contracted pelvis, it should not be resorted to when this diameter is reduced below three and one-fourth inches, provided it be a standard which head present.s

Determination of the wisest course to pursue in case of pelvic contraction and consecutive dystocia is beset by many difficulties and involves weighty responsibilities. Our choice of measures may lie betwixt protracted use of the forceps, with powerful traction, podalic version and pubic section ; or, between Cæsarean section and this operation. The difficulty lies in the uncertainty of one of the important elements of the case, namely: the exact size of the fœtal cranium. This can best be estimated by means of careful manual exploration, and in general, upon such inaccurate evidence must our decision finally rest.

As an aid to estimating the possibilities of delivery through the adoption of the measures at command, we should recall the position ordinarily assumed by the head at a contracted brim, in response to wise efforts of the natural forces to make the best use of their energies, which

is with the bi parietal diameter in correspondence with the pelvic conjugate.

The operation. The woman having been prepared with scrupulous care, and all the other essentials of an aseptic procedure having received attention, we are ready to proceed with the operation. The table should be set as for a cœliotomy, assistants similarly placed and the other details comformably arranged. Failure to do this seriously compromises our chances of complete success. The method which I shall first describe, and that, which, from both experience and study I am led to regard as preferable, is known as the subcutaneous, though it is not strictly such. An incision of about two inches is made in the median line, the lower end of which laps a quarter of an inch upon the superior margin of the pubic articulation.

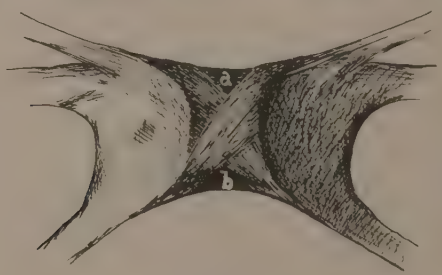

FIG. 8.

The symphysis pubism: "a" suprapubic ligament "b" subpubic ligament.

The recti muscles being exposed, a few of their fibres are severed by a small transverse incision between the pubic spines, and the index finger is passed along the inner surface of the articulation, gently pushing aside the retro- A sound may then be passed into the urethra and this part held aside by an assistant, if prefered, though I believe that the interposed finger is capable of affording ample protection. With an ordinary, curved, probe pointed bistoury, the ligaments which bind the articulation are carefully severed from above downward, the last to be cut being the sub-pubic. Although the original incision does not descend to much depth upon the anterior face of the symphysis, every facility for making the necessary division is afforded by the mobile tissues. As soon as the

sub-pubic ligament is severed, the pubic bones fall apart, the articular surfaces separating an inch or more, too wide separation being prevented by bi-trochanteric support.

Unless vessels of some size have been cut, artery forceps may be dispensed with, at least for the time being. the wound being temporarily filled and covered with gauze, The thighs are then lightly flexed, the forceps is applied

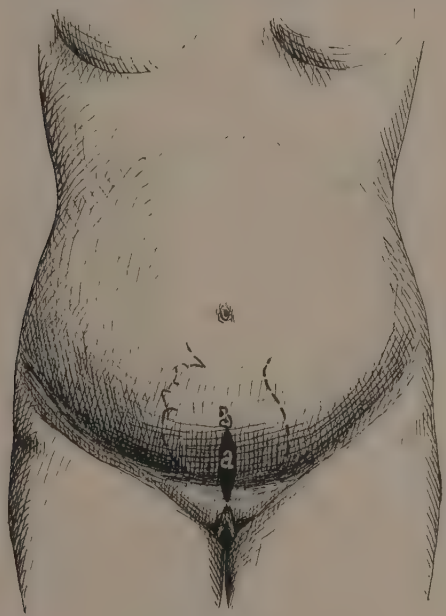

FIG. 9,

"a" the location and extent of incision in symphysiotomy.

pubic tissues, until it reaches the crown of the pubic arch. and delivery effected, all of which can be done with ease, provided the disproportion between head and pelvis be not too great. In certain instances it may be advisable to deliver by podalic version. During extraction, the trochanters are firmly supported by the hands of an assistant to prevent an unnecessary degree of pubic expansion with consequent injury to the sacro-iliac articulations and the soft tissues situated anteriorly at the site of greatest strain.

Delivery having been completed, the patient is returned to the primary position on the table and attention given the wound. The gauze will be found well saturated from capillary oozing, but it is not often necessary to ligate many vessels. When the articular surfaces are being brought into apposition, the finger should be passed behind the symphysis to make sure that neither bladder nor urethra is being pinched, as cases of urinary fistula arising from such a cause have been reported. It probably is not necessary to apply any buried sutures with especial reference to the maintenance of articular approximation, though in one instance I did so.

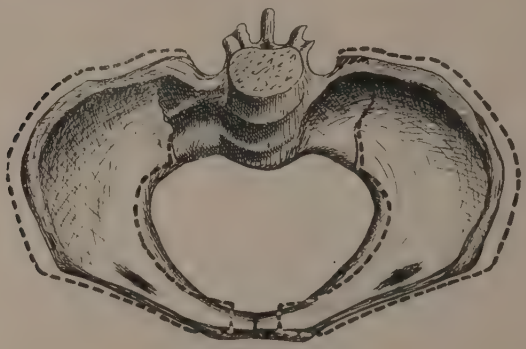

FIG. 10.

Showing separation of the innominate bones and increase of pelvic diameters after symphysiotomy

After disposing of all bleeding points, either by temporary compression with hot sponges, or by ligature with fine silk or cat-gut, the wound is closed by silkworm gut sutures, which take deep hold upon the tissues, and especially upon the fibrous covering of the pubic bones, so as to insure good apposition. The wound is dusted with iodoform, boric acid, aristol or campho-phenique, several thicknesses of aseptic gauze are applied, followed by a heavy layer of absorbent cotton, the whole being held in place by broad straps of adhesive plaster which nearly encircle the body. The last act, that of tightly bandaging the hips, is of the greatest importance, and to make sure of firm support, it is well to prepare for the purpose a many-tailed bandage of unbleached muslin, or other firm goods, which is to be evenly and firmly applied.

For the first two or three days the dorsal position, with the thighs somewhat flexed, is usually preferred, after which a lateral posture may be assumed by degrees, the woman being gently turned from side to side. In my second case I kept the patient in a lateral position for the first few days, and I fear that this had an unfavorable influence by retarding recovery.

The nurse is required to spare no pains to keep the dressings and bandage dry. As the latter envelops the hips as well as the abdomen, descending much lower than the ordinary obstetric binder, it is peculiarly exposed to soiling by the lochia. To prevent this the vulvar pad is made unusually thick and is frequently changed. The urine is drawn for several days. It may be necessary to loosen the lower margin of the bandage in order to make use of the bedpan.

The firmness of the bandage is tested several times a day, and tightened at individual knots as occasion may require. When application of a fresh bandage becomes necessary, the trochanters are firmly supported by the hands of an assistant so as to avoid all strain upon the reuniting surfaces.

The operation of symphysiotomy has been modified by Dr. Edward A. Ayers, in a manner which gives promise of still better results. It is the only true subcutaneous method. He has had experience with the operation in five cases, the maternal recoveries being in each instance, save the last, most satisfactory. The simplicity of the method is so striking that I am constrained to give it proper mention. Following is the description of his operation:

> The patient being brought to the edge of the table, with the thighs flexed upon the abdomen, and the vagina and vulva properly cleansed, a small male urethral sound is used to hold the urethra and lower portion of the bladder to the patient's left. The labia minora and clitoris are then drawn well up, and to the patient's left. The operator's left index finger is next introduced into the vagina and pressed against the posterior groove of the symphysis up to the top of the joint. A small incision is made about one-half inch below the clitoris.
>
> A curved probe-pointed bistoury is then passed through the wound, close against the joint, to the top of the symphysis, until it is felt by the tip of the left index finger. The blade now lies under the vessels of the clitoris, and need not cut any arteries. As the pubic bones are V-shaped in front, I believe it is easier to enter the joint from in front than from behind. Moreover, the left finger being in close contact with the posterior groove of the joint, and the fingers holding the bistoury being very close in front, still greater facility is afforded for finding the joint. The bistoury is now worked carefully down through the symphysis, and the amount of section determined by the separation that ensues, the left

finger being a constant guide to the amount of separation. For separating the subpubic ligament, it may prove best to change the direction of the bistoury, and cut up instead of down. The curved probe-pointed bistoury is not necessary, and is slightly objectionable in that its backward curve forces the soft tissues lying over the joint farther away than if it were straight. A slender, long, tenotomy knife can be used with much grace and safety, beginning the incision along the middle of the joint, and working upward and downward. I used such a one in Case IV. The cutting edge being only an inch long, there is no danger of cutting the subpubic vessels, when the handle is properly lowered. The guiding finger posteriorly will keep the urethra and bladder out of danger. A bistoury whose cutting edge is not over one and one-fourth inches long at the probe end, and whose shaft curves like a sigmoid, is the best. I am having such a one made. I do not think there is any comparison between this method and Morisani's. While it has all the advantages of Pinard's open method, it avoids the vessels of the clitoris by passing under them then if they are torn in delivery, they will not bleed so readily as when cut. In my five cases, there was no hæmorrhage of any moment, or any difficulty in finding the joint or making the section. The wound enlarged to the size of an inch during a two-inch separation. It is easy to check hæmorrhage with gauze and fingers. I think I would prefer Pinard's method in symphysiotomy for impacted posterior-occipital and face presentations, which will probably come within the scope of symphysiotomy before long, as it would be difficult to introduce the finger well up behind the joint. In the after-treatment of my patients, I have lightly packed the wound with iodoform gauze, put my usual gauze dressing over the vulva, and strapped the pelvis from side to side across the mon-sveneris with plaster strips. The gauze is removed in thirty-six hours, and the vulva and vagina kept thoroughly clean by means of bichloride irrigation. Catheterization can be done without risk of infecting the wound. In no case was it required more than twice. No special elevation of temperature occurred.

"In Case III., I stitched the perineum with silkworm gut. I shall refrain hereafter from stitching cervix or perineum, as the removal of the stitches interferes with the immobility of the joint. Our judgment is better balanced when we give first regard to the symphysis, and reserve repair of the soft parts for a secondary operation. There is no added danger of infection from torn cervix or perineum, with careful daily irrigation of the vagina."

The open method of Pinard differs chiefly in the extent of the incision, the lower end of it terminating at the root of the clitoris. The principal advantages claimed for it are, easier access to the articulation, and division of it under the eye, which, we believe, are counterbalanced by increased hæmorrhage and augmented danger of infection.

The general regimen should be that commonly accorded patients, who have undergone cœliotomy, total abstinence from food and drink being enforced during the first twenty-four hours, after which a light diet is maintained until all the early dangers have passed.

The recumbent posture is rigidly enforced for a period of three or four weeks, and the patient is not allowed to take her first step within five weeks.

Artificial Widening of Contracted Pelvis. Wihl Pooth of Cologne has operated in three cases of contracted pelvis in a manner to insure permanent enlargement of the pelvic diameters. He makes a transverse section of the front of the pubic bones, taking off the corners, the two making a plate of bone about 3 etm. long and 1½ ctm. broad, and including nearly half the thickness of the bone. Section is then made posteriorly so as to open the joint, and the delivery effected. He then freshens the articular surfaces of the symphysis, interposes the plate of bone removed from the face of the pubes, and stitches it in place.

Bony union has taken place in every case, and the pelvic diameters have been increased from 1¼ to 1½ ctm.

Ischio-pubiotomy. I should not fail to refer to a congener of symphysiotomy, known as Farabœuf's operation, which consists of section of the pelvis at a point to the right or left of the symphysis pubis, according to the direction of the pelvic contraction. It is intended for cases of obliquely contracted pelvis wherein symphysiotomy would be comparatively ineffectual. One of the most recent examples of this operation of which I have seen a report, is from the clinic of Prof. Pinard, of Paris.

In order to make the result of this operation satisfactory, the greatest care will be requisite, owing to the presence of the obturator nerve, which supplies the adductor muscles of the thigh, at the site of the intended section. In measurements recently made on the cadaver, I find that the point of exit of this nerve, at the upper and inner margin of the obturator foramen, is just two inches from the symphysis. The obturator vessels are also found at the same point. To go to the outer side of this opening would materially diminish the danger of section, but the operator must recollect that the nerve there lies close to the lower border of the horizontal ramus of the pubis. If section be made at a nearer point, the body of the pubis alone will be cut, and, owing to proximity of this line of incision to the symphysis, the special advantage of the operation over symphysiotomy will be measurably diminished. The best point for section is probably about two and one-half inches from the symphysis. The direction of the section will be downward and somewhat inward, the chain-saw cutting first the transverse and then the descending pubic rami. Of course the obturator nerve can be avoided by careful adjustment of the saw about the transverse ramus.

Complications. Among the complications of symphysiotomy occasionally met, I may mention bony anchylosis of the articulation, which resists the knife and necessitates use of the chain-saw. Again, firm engagement of the head at the superior strait will make severance of the bone more difficult and dangerous, owing to the scanty room found behind the symphysis for the directing and protecting finger. In such a case the woman should be put in Trendelenburg's posture, when, if the head does not become spontaneously disengaged it may be released by pressure through the vagina. The necessary cutting work can then be done with ordinary ease, after which the woman will be returned to the horizontal position for delivery. Should the head be firmly wedged in the pelvis, the long incision recommended by Pinard is preferable, since it affords a better opportunity to open the symphysis from the anterior face of the articulation.

Hæmorrhage, which is so common with the last named method, rarely requires special attention when the subcutaneous operation is adopted. Should there be unusual bleeding, the severed vessels will of course be ligated, and capillary oozing controlled by pressure with hot gauze sponges. When the oozing is not completely arrested by this means, it is well to make temporary drainage.

The ultimate results. There is but little for us to add with respect to these, inasmuch as the uniformity of reports concerning them appear to settle the question beyond rational controversy. The chief fear has been that the articular surfaces would not reunite with sufficient firmness to perfectly restore the powers of locomotion. But, as remarked at the beginning, this fear has been shown to have slight foundation in the facts of clinical experience. Still there is every reason for exercising the greatest care in management with a view to preventing such an effect. Thus far fear has doubtless exercised a favorable influence by urging to the observance of precaution, especially in the direction of prolonged recumbency, which is doubtless essential; and no modern operator has either the temerity or the disposition to adopt a less rigid régime.

XV. Retro-uterine drainage. By Dr. R. Ludlam.—With the growing fondness for something new, and the frequent changes in the technique of abdominal surgery, there is danger of forgetting some of the older methods

that are really useful. One would suppose the remarkable success that is attendant upon vaginal hysterectomy could not fail to keep the idea and the possible need for vaginal drainage constantly in mind. If we grant that in the great majority of cases of laparotomy with strict asepsis and a careful operative technique, all kinds of drainage are unnecessary, there is still a small share of them in which in some form it is indispensable. Hence it may become a serious question as to which is the better way.

My practice has been sometimes to use the supra-pubic method with the glass tubes of Tait, or Bantock, or a Sims' hard rubber tube; sometimes the simple gauze drain, and again that of Mikulicz; and sometimes the capillary drain, which is perhaps better than none. But while they have often done good service, I have found them to be more or less mischievous because of the frequent dressing and the exposure of the wound required in keeping them clean, and from the possibility of their becoming an added source of infection. The tubes may be choked with clots, or omentum, or for various reasons may fail to empty the Douglas pouch in an up-hill manner; and, except as a surface drain beneath the incision, the gauze may not only cease to be sterile, but may so cork up the wound as not to carry away the infectious discharges. Therefore, while I have learned that drainage can often and usually be dispensed with; and while, when it is required, I am in the habit of choosing the upper or the lower method according to the case in hand, without committing myself exclusively to either of them, my experience proves that the retro-uterine plan first proposed by Sims is the better one. That plan consisted in passing a perforated rubber tube through an opening in the roof of the vagina behind the uterus. One end of the tube was carried out at the lower angle of the abdominal wound, the other being in the vagina, and a stout silver wire was left in the tube to keep it in line and patulous.

I first used that kind of tube in an ovariotomy, December 26, 1872, before the days of asepsis and antisepsis. The case was a desperate one, but the patient's life was

saved by repeatedly showering and flushing the abdomen and the pelvis through the tube from above. At present the long tube and the wire are unnecessary. When the toilet of the peritoneum has been completed and we are ready to close the abdomen, the vaginal roof is pierced and an ordinary rubber drainage tube that is thoroughly aseptic, split and spread at its upper end, is drawn half through into the vagina and left there. The vagina is lightly packed around it with iodoform gauze, which at the proper time can be removed and replaced, and the douche carefully given.

The advantages of this method are: 1, that after the first twenty-four hours the patient is not obliged to lie all the while upon her back; 2, the abdominal wound being let alone, free from disturbance and exposure, there is no danger of hetero-infection from that source; 3, constant and more perfect drainage is secured by gravity; 4, if it becomes necessary the pelvis can be thoroughly flushed from below at any time; 5, the tube may be left in situ indefinitely; 6, as the vaginal wound heals spontaneously, the same as after a vaginal cœliotomy, and that of the abdomen will have closed throughout by first intention, there is no consequent risk of fistulous tracts, or of a ventral or any other form of hernia; 7, by keeping the abdominal cavity and the pelvis free from exudates there will be fewer adhesions than by the upper method; and, 8, the convalescence is relatively more rapid and constant.

The following is a brief abstract of three desperate cases occurring in my clinic in the Hahnemann Hospital during the present winter (1896-97) in which there is every reason to believe that recovery was due to the adoption of this very simple and efficient method of drainage:

Case 1. Intraligamentous abscess the sequel of extra-uterine pregnancy. Mrs. — —, æt twenty-three, no children, skipped her menses four years ago for a period of six months. From the usual signs she was thought to be pregnant, and a doctor passed a rubber bougie into the womb and left it there for three months. From that time

forward her health was wretched. Five weeks before coming to the hospital she had been treated for a fortnight for typhoid fever. Her symptoms before the operation were a sensation as if an iron ball were lodged in the left lower pelvis; constipation and pressure on urination; anæmia and great debility; tympanitis and excessive abdominal tenderness at the month; copious sweating; morning temperature 100–101°, evening ditto, 103°. There was an immovable tumor in the left pelvis that nearly obliterated the bowel and pressed the uterus toward the opposite side. On opening the abdomen that tumor proved to be a large abscess in the left broad ligament, which was emptied by careful aspiration of a lot of dirty, stinking pus; the hæmorrhage was checked by flushing; the sac cleansed and the rubber drainage placed behind the uterus. The temperature came down at once, and there were no signs of surgical infection. The tube was worn for a fortnight and the recovery was perfect.

Case 2. Cysto-carcinoma of both ovaries complicated with a parovarian cyst. The patient, aged forty-two, was sent to me by Dr. Ripley, of Kenosha, Wis. Both ovaries were cysto-carcinomatous and, beside a lot of ascitic fluid, there was a large parovarian cyst which was so extensively and intimately adherent to the intestines, on its posterior face especially, that I was obliged to stitch it into the abdominal wound, as we do in advanced extra-uterine pregnancy. The vitiated and highly septic character of the fluids and the almost rotten texture of the larger of the two ovarian tumors made it necessary to resort to drainage. But, the posterior portion of the parovarian sac having been so torn by manipulation that it could not be closed off, anterior and upward drainage would almost certainly have failed. The double ovariotomy therefore ended with placing the the retro-uterine tube as already described. That tube was worn for a month, and, excepting a mural abscess which gave her some trouble, she gained strength and color steadily with a slow and sure convalescence, which, without the drain would, I believe, have been impossible.

Case 3. A large, multilocular ruptured ovarian cyst, with ascites and procidentia uteri. Mrs. ————, aet. twenty-seven, kindly referred to my clinic by Prof. Shears was extremely weak, feeble and emaciated. She had had three children, but since the birth of the last one, four years ago, had not menstruated. Two weeks before the operation she was struck on the abdomen by her child.

The blow induced fainting and a wretched feeling of pain and collapse that kept her in bed for some days, after which she had fever, rapidly failing strength, loss of flesh and insomnia. The abdomen was very large. There was decided fluctuation in the iliac and hypogastric regions, some resonance in the right hypochondrium, but dullness in the left side to the costal margin. The evident ascitic deposit had inverted the posterior cul-de-sac and forced the uterus entirely out through the vulva, so that its fundus lay upon the table, while the os uteri looked directly toward the horizon.

A slight abdominal incision, being carefully made, discharged the free ascitic accumulation, which was intimately mixed with a sticky, olive-colored ovarian fluid. There were wide bands of dense and firm fibrous adhesions to the left parietes (which had furnished an element of confusion in the diagnosis), and scattered, more delicate adhesions to the omentum and the intestines. The pedicle was very broad and was secured with the cobbler's stitch. The mother cyst was unusually large and its contents proved afterward to be of the nastiest possible description. The smaller cysts of which there were many, were filled with colloid material, the chocolate fluid, blood, pus, etc. The tumor and contents weighed forty-seven pounds.

When the growth was turned out entire and without tapping through an incision of fifteen inches, the one cyst which had evidently been ruptured by the blow of the child before the patient entered the hospital, was found upon its upper and posterior surface, so that the score of the accident and the cause of the admixture of the ascitic and the ovarian fluids was plainly evident to my assistants and to the sub-class. This fact, and because the Douglas pouch had acquired an enormous size through its prolonged distention, furnished the strongest possible indication, I thought, for drainage, and especially for drainage by the lower route. A rubber tube was accordingly inserted through the vaginal roof, which had been reposited, and the abdominal wound was completely closed. The convalescence was similar to that of a natural labor; the temperature did not once reach 100°, and, as there were no symptoms, she took no medicine whatever.

Discussion: Dr. Shears: One of the cardinal principles in general surgery is that drainage should be made from the most dependent point, and I see no good reason

why this should not hold true in abdominal work. I am therefore an advocate of drainage of the abdomen by the vaginal route whenever this can be done without interfering with important structures. I favor it also because I believe drainage by this plan does away with one of the greatest drawbacks to abdominal work, namely, ventral hernia. It has been my observation that where drainage has been continued through the abdominal incision for more than twenty-four hours ventral hernia is liable to occur. I know some surgeons do not admit this, but I am inclined to believe that, did they follow their cases for a period of two years after operation, they would find that, in many instances the wall weakens and gives way at the point of drainage.

VOLUNTEER PAPERS. XVI. CASES FROM PRACTICE. By DR. M. C. STURTEVANT.—*Case 1. Puerperal convulsions.* I was sent for eight miles in the country to attend a III-para in labor at term. Her former labors had been natural, and her puerperal convalescence also. At 3 A. M. she was taken with nausea and vomiting. She had two labor pains, according to the mother's report at 10 A. M., but the third pain resulted in a spasm and no more expulsive effort on the part of the uterus. When I arrived she had had a dozen or more convulsions, passing from one into another without any sign of returning consciousness. Local examination found the os patulous, but not dilated; the parts moist and natural, but there was no apparent progress toward delivery. The convulsions were general, very severe, jerking and clonic, with frothing at the mouth at times, and a swollen and besotted look of the face and eyelids. The pupils were dilated and the eye-balls rolled upward. There was only a little bloating of the extremities. The urine had not been examined.

Because of the slight cervical dilatation and the nervous tension I gave her gelsemium tincture in five drop doses, repeated every fifteen or twenty minutes for a few times. Then I found some yielding of the os uteri, and changed to magnesia phos. 3 decimal trituration, which was given in the same way for awhile. The spasms were lighter and the interval between them was lengthened, each spasm being a misplaced pain. Between 2 and 3 P. M. the fits

ceased, but she did not show signs of returning consciousness until the third day.

When the fits had ceased I continued to dilate the os manually. At 4:30 P. M. a pretty full dilatation was accomplished, but in making out the position she had a violent fit, and then I finished delivery with the forceps. There seemed to be no expulsive effort of the womb until the head was drawn down into the lower strait, when, after acting with the pains, and resting meanwhile, the child's head was delivered, after which she had only three slighter spasms. The child had evidently been dead from the start of the trouble. There was no swelling or irritation about the breasts and no milk came. The pulse was about 140 for three days, the temperature varying from 102 ° to 99 °. Otherwise her convalescence was not unusual and her recovery was complete. But the peculiarity is that she has no recollection of being pregnant or of having had a child.

Case 2. Magnesia phos. in spasms. I used the magnesia phos., because of my success with it in all forms of spasms in which I had given it before. Indeed, I had one case in which a child about a year old had been away on a visit, and according to the word that the parents gave me, it had had 400 spasms, and was sent home to die or to develop idiocy. I gave it magnesia phos. 3 trituration only, and it had but three spasms after that; nor has it become an idiot yet.

Discussion: Dr. A. L. Blackwood: Magnesia phos. is a remedy I have used extensively in convulsions and spasmodic affections when of a purely nervous origin. But I would not place much confidence in it when the convulsions are due to a toxæmic condition.

In the case reported by the doctor I would attribute more to the gelsemium, which is frequently the remedy in these conditions.

Dr. H. V. Halbert: Magnesia phos. is a remedy not to be overlooked in nervous conditions. Whether the spasms were relieved, in Dr. Sturtevant's case, by the use of this remedy or by local measures I am not prepared to state. Without doubt the local condition was sufficient to create the disturbance. However, we have reason to believe that the remedy might have been an adjuvant at least. It cer-

tainly has a wonderful action upon the cerebral cortex and therein it possibly thwarted the reflex excitement, while the local relief was necessary to recovery, nevertheless the remedy may have overcome the cerebral excitement. The magnesia salts are surely a tonic in nervous debility and they correct the loss of brain inhibition. When the brain condition is perfect a spasm is not possible unless there is great reflex disturbance, or some toxic cause exists. I have used this remedy successfully in cases of sensory epilepsy when there were not severe tonic and clonic spasms, and when the loss of consciousness was not complete. I think we may well consider the clinical experience which Dr. Sturtevant has given us.

Dr. ORRIN L. SMITH: Symptomatically or otherwise employed, Dr. Sturtevant's dictum—never carelessly given—as to the efficacy of Schussler's anti-spasmodic, deserves more than passing notice. I am perfectly free to confess my skepticism as to its efficiency in such conditions as puerperal eclampsia, but can testify to happy results attending even its empirical use in the convulsions of childhood. I believe, however, that its beneficial effect should be ascribed to the phosphorus contained in the preparation. My own experience and the observation of others have taught me that the majority of these convulsive attacks occur in children during the summer months, from intestinal irritations and catarrhs, and chiefly in rachitic or neurotic children. So, by attaching the well-known and satisfactory action of magnesism in these bowel complaints to the proven stimulative and rapidly nutritive effect of phosporus upon the irritable and depleted lower sensory motor tiers of Jackson—which in childhood are deprived of the inhibitory influence of the as yet imperfectly developed higher tiers—and the anabolic sympathetic branches, we have clinically evolved an almost perfect remedy that acts more promptly when administered in hot liquids, for the busy practitioner in this particular class of convulsions.

XVII. An operation for ingrowing toenail. By Dr. Chas. S. Mack.—I think that decidedly the best cutting operation for ingrowing toenail is that I am about to describe. I think it has never been published; I have described it to many brother practitioners, but never yet to one who had previously heard of it. I learned it many years ago of an old-school friend who had practiced it much and who prized it highly. It has served me well and it will, I feel sure, be adopted in many cases to the advantage and satisfaction of both patient and surgeon.

Anæsthetize the patient. To render the operation bloodless, tightly bandage toe from tip to base, and, having tied an elastic ligature around base of toe, remove the bandage.

Make incisions *a*, *b*, *c*, and *d*, *e*, *f*, so deep that line *a*, *d*, shall coincide with edge of nail. At edge of nail make incision *a*, *d*, perpendicular to plane of sole of foot, and so

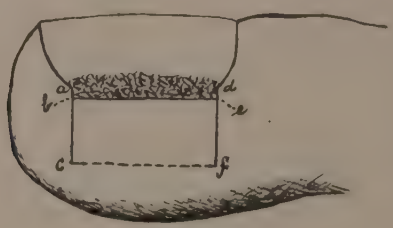

Fig. 11.

deep that its deepest part (which is hidden) will read to plane of dotted line *c*, *f*.

Make the incision *b*, *e*, just skirting upon the proud flesh, but not including any of it. Make this incision in such direction and so deep that its deepest part (which is hidden) will reach to plane of dotted line *c*, *f*, and will coincide with deepest part of incision *a*, *d*. Lift out the wedge whose base is represented by *a*, *b*, *d*, *e*, and whose thin edge (hidden) is on the plane of the dotted line *c*, *f*.

Now you have removed all the proud flesh, and have made the small flap *c*, *b*, *e*, *f*. Two fine sutures (perhaps of horse hair) will fix this flap. A dry dressing (say of aristol) may be left in place a few days until strong union by first intention has taken place. I have never known of continuance or of recurrence of the trouble after this very simple operation.

Editorial.

THE NUMERICAL WAVE IN MEDICINE AND SURGERY.—A highly valued correspondent writes as follows :

The vice of statistics is apparent not only in surgical procedures but in those which are medical as well. How often is the attention called to papers and reports entitled thus : A *résumé* of fifty cases of scarlatina in which, etc., etc.;" or " Forty-two cases of erysipelas treated with, etc.;" or "A synopsis of twenty-seven cases of diphtheria under the administration of, etc."—the inference being that the next series of cases will be exactly like the previous ones, and that they will respond in the same way ! Nor is anything said of the possibility that a certain proportion of those cases would have recovered under some other treatment.

A remedy that is suited to an epidemic in one season may prove an utter failure in the next one; so that any number of cases successfully treated in one year by a certain method does not argue against the fact that it may show up very differently under changed conditions in the next year. The numerical method is fallacious, even if errors in diagnosis were left out.

Sidney Smith has said that nothing is so deceptive as figures except facts. Whoever devises a new method of treatment, or of operating, is likely to develop a habit of classifying his results that is calculated to bring its author into notice, whether it benefits anybody else or not. And so it usually happens that the ebb and flow of medical fashions and reforms have their corresponding wave of statistics that may or may not merit our confidence.

In estimating the result of any kind of treatment whatever the sources of fallacy are so numerous, and the truth is so elusive, that everything depends upon who makes the figures, and who arranges and records the facts. For if one is too eager and enthusiastic, or too careless and ignorant, his statistical tables will prove just what he wants them to. If he knows little and cares less about the end-

less variety of morbid conditions and complications, or of the vital resistance against the invasion of disease and against the propensity of the doctors to interfere and to overdo, his facts will take the same squint and complexion. Each has a limping method of analysis that leads to wrong conclusions. Such pseudo-statistical tests put a premium on quackery, make it next to impossible to discriminate between the true and the false, and betray a kind of moral paresis that is very damaging to the interests of the profession.

When it concerns a mode of practice that has ripened and survived the infantile fuss that was probably made over it at the beginning, we can compute the amount of clinical evidence for and against it, and thus arrive at a definite and positive conclusion regarding its merits. A trustworthy calculation can be made in no other way. All veally sentiment and narrow partisanship must be excluded, and the Civil Service principle righteously applied to our professional resources before we can know just what we have to depend upon.

When the claims of the antitoxin method shall have been as fully tried and rightly judged by the majority of physicians as those of vaccination have now been; when antisepsis has been tested as thoroughly as anæsthesia; when the advocates of some of the newer modes of operating can show as many triumphs as we already have for ovariotomy; and when the merits of electricity, suggestion and faith—if they are ever to be clinically valuable, shall finally be presented with scientific accuracy and absolute fairness, there will be no discount of the figures that are offered, and no drawback because of an exaggeration, or a misstatement of the facts in the case. For then we shall know what dependence to place upon them, and what methods we may safely receive or reject.

Hospital Notes.

THE CLINIC ON DISEASES OF THE EYE.

SERVICE OF PROF. C. GURNEE FELLOWS.

BLEPHARITIS FOLLOWING MEASLES.—*Case.* Bessie ——, aged three years had an attack of the measles about three months ago, since which time her eyes have been sensitive to the light, the lids thick and reddened, constantly covered either with a sticky, thick discharge or dried scabs and scales; the eyelashes are gone in places, and matted together in others. The eyeballs appear somewhat inflamed. The child goes about with one or the other eye closed, and although not suffering from the presence of light, yet avoids the brightest sunlight.

The attention of the sub-class is called to this child not so much for this individual case as that it represents a class of cases which you will often meet in general practice.

Please look at the child as she sits before us. Ask her to open her eyes and look at us, and with an effort she does it; which shows that in all probability the cornea is not involved; for if it were, the child could hardly open her eyes, as she sits facing the window. Look closely and you will see that the conjunctiva is not acutely inflamed, but presents a deep red color and a soggy appearance more like a chronic inflammation.

The margins of the lids are thick, and the mouths of the Meibomian glands are mechanically closed, with here and there white nodules showing where an exit is about to be made by the bursting of a tiny abscess. The lashes are stuck together in bunches, and the lids have an altogether unclean appearance.

There is possibly at first thought nothing of apparent interest in this case, and you could dismiss it with the prescription of any one of a dozen remedies and the advice, "keep it clean;" but such cases as this, cured promptly, will do you as much or more good in your field of practice

than some bloody operation which at present seems more to your taste; but you will find that the little things are of great importance, and the little ones, to the mother's eye, of most importance; and I therefore dwell at length upon the details in the treatment of this case.

First of all, *cleanliness* is essential. It is utterly useless to have the child wash out her own eyes, or even to have the mother do it with the family wash rag. Adding antiseptics to the water will hardly improve the matter.

I always believe in using the simplest means and those easiest of access and you can treat such a case as this in any house. Sterilized water can always be obtained by boiling. An impromptu solution of bicarbonate of soda, found in every kitchen, can easily be made, and with pledgets of absorbent cotton or old linen, the eye may be washed, the scabs soaked up and loosened. There are some which will be particularly hard to remove, which may need longer soaking and a little assistance from an instrument, very easily improvised from a common wooden tooth-pick, or if necessary, the cleansed and sterilized finger-nail. Now with a little more washing with your soda solution, the lid is clean, and the mother has been taught how to do it, and can thus cleanse it from one to a dozen times a day, if necessary.

If you do nothing else but cleanse it, and do it carefully and persistently, and then prescribe the homœopathic remedy, you will be pleased with the results.

It is also well to annoint the lids with plain or weakly carbolized vaseline at night. This much of treatment is essential. Now from a technical standpoint you may add to it as much as you please of what follows. Your antiseptics for local cleanliness may be solutions of boracic acid, 10 per cent, bichloride of mercury, 1 to 10,000, permanganate of potash, 1 to 500, listerine, katharmon, glycothymoline 1 to 8 or 10, or a host of well known or well advertised preparations. Each, any or all of these will answer the purpose.

Now if for the simple vaseline you wish to substitute

the yellow oxide of mercury 1 per cent, boracic acid ointment graphites or calendula cerate, you may be still better pleased. To this add the careful selection of the homœopathic remedy, and you will have done the best for your patient.

Remedies. The one remedy most commonly indicated, and the one that I have found of most value, is graphites. I use it in the sixth, twelfth and thirtieth potencies.

Another very important remedy is argentum nit. 6x, 12x, and 30x. Other remedies the indications for which will naturally suggest themselves are mercurius, hepar sulph., silicea, calcarea, zincum, pulsatilla.

We will put this child upon the following treatment: Thorough cleansing of the lids with boracic acid solution, three times a day, graphites cerate applied at night, graphites 30x three times a day. I am confident this child will improve at once, but even when the local conditions are improved, I advise you to continue your internal constitutional remedy for some time in order to prevent a recurrence.

[A subsequent report shows this child practically cured at the end of three weeks' time, and it was dismissed with a prescription of graphites cc. to be continued at intervals for three months.]

Clinical Reviews.

All books for review, magazines, exchanges, correspondence and articles designed for publication in this journal should henceforth be sent to Dr. R. Ludlam, Editor, 1823 Michigan Avenue, Chicago.

TRANSACTIONS OF THE HOMŒOPATHIC MEDICAL SOCIETY OF THE STATE OF NEW YORK. Vol. XXXI., 1896. With a general index for ten years. 8vo., pp. 503.

This clever volume, which reports the forty-fifth annual, and also the forty-fifth semi-annual, meetings of the New York Society, is a fit companion for those that have preceded it. The clinical papers presented by the various sections, the work of practitioners, specialists and teachers, and the brief, crisp essays and discussions by those who were careful not to fall into the snare of special pleading, are very commendable. The obituaries contained in the appendix embalm the memory of some of those passed-away friends who helped to make the society an honor to the profession and the country; and the taste and spirit of the book are excellent.

A COMPEND OF THE PRINCIPLES OF HOMŒOPATHY AS TAUGHT BY HAHNEMANN AND VERIFIED BY A CENTURY OF CLINICAL APPLICATION. By WM. BŒRICKE, M. D., Professor of Materia Medica and Therapeutics in the Hahnemann Hospital College of San Francisco, Etc., Etc. San Francisco: Boericke & Runyon. 1896.

There are two potent reasons why this will prove a most acceptable and useful book: *First*, it is needed by many of our own faith to justify and fortify their belief in the law of similars; and *second*, it will serve an excellent purpose in the hands of those old-school physicians who are looking about them for a better way, who wish to know what our belief is, and why we hold to it. The tone and breadth of the work are shown in the following extract from its preface:

This little book is intended to be an introduction and aid to a fuller study and wider acceptance of Hahnemann's doctrines. It does not pretend to be more than an attempt to elucidate the salient and vital points often abstrusely and always metaphorically treated by Hahnemann, and thus to familiarize the student with the fundamental ground-

work of our school. These essential doctrines do not include the necessary acceptance of every statement of Hahnemann as of equal and absolute importance. Indeed, a wise discrimination is necessary, for the minor things may be instructive or obstructive, or even destructive, according to the way they are held; they may, therefore, be useful or otherwise for the mental development of the physician or the scientific evolution of the school.

There are brief and explicit chapters on The Therapeutic Field; Principles of Pharmacology; The Homœopathic Materia Medica; Drug Proving; Interpretation of Drug Pathogenesis; Drug Relationship; Applied Homœopathy; The Similimum; Hahnemann's Nosology; Posology and Homœopathic Pharmacy. And, what is quite as important, valuable and welcome is an appendix of some forty pages entitled, A Catechism on Samuel Hahnemann's Organon, and on the first volume of his Chronic Diseases, that was carefully and conscientiously prepared by our dear old friend, the late Dr. Samuel Lilienthal. This will prove a necessary and serviceable compend not only for students but for physicians of all schools.

FIVE YEARS' WORK IN SURGERY. Comments and deductions based upon a series of thirteen hundred and eighty-seven operations. By HORACE PACKARD, M. D., Professor of Surgery, Boston University School of Medicine; Surgeon, Massachusetts Homœopathic Hospital, Etc., Etc.

In this modest volume Dr. Packard, the Boston surgeon, makes a good showing of five years' work in his specialty. It embraces the essential history and surgical treatment of a large number of cases, most of which were of a serious kind. The chosen technique, the tabulated results and the practical lessons drawn from his varied and extended experience make the book worth having and worth keeping. It is finely illustrated with original cuts and drawings, is in no sense an advertisement, but a dignified and trustworthy record that will always be a credit to the school, the hospital, and the city from which it came. We congratulate the author on what he has accomplished, and the profession of New England upon having the skill and counsel of such a worker within easy reach.

Miscellaneous Items.

A most cordial invitation is extended to the graduates of the "Old Hahnemann" to attend the annual meeting of the Alumni Association at the College on the evening of March 24. The Committee has arranged for a grand rally and assures everybody that, while plenty of good things will be furnished, no subscriptions or donations will be asked for or expected.——The XXXVIIth Annual Commencement is set for the next afternoon, the 25th, at the Grand Opera House, to be followed by the banquet at the Auditorium. Come right along!——By a stupid blunder on the part of the Editor, Prof. Shears' name was not attached to his excellent portrait facing page 102.——The total membership of the American Institute of Homœopathy for '96 was 1,616.——The Ladies' Benefit Concert for the Hospital yielded $1,650 net, a glorious result for an impromptu affair.——Having hurriedly left Greece, Prof. Dunn is out of the fat and into the—ship on his way home.——Prof. Croftan is in California; Prof. Bailey at Mardi gras, in New Orleans; Prof. Halphide in close quarters with a sprained ankle; and the Class is busy with the Examinations, which began March 12.——The Section on Sanitary Science, Dr. C. E. Colwell, Chairman, will report at the next meeting of the Clinical Society, Saturday, March 27.——"The Eye as an aid in General Diagnosis," a new book by Dr. E. H. Linnell, will appear in a fortnight.——The Federation of Ladies' Circles will hold a reception at the hospital on Hahnemann's birthday, April 10.——Under the lead of Dr. A. R. Wright, the local committees are making thorough preparation for the next meeting of the Institute, in Buffalo, June 23–30.——Good old Dr. Lewis Halleck, of New York, died March 4, æt. 94. He was one of the original founders of the American Institute in 1840.——Prof. Leavitt's monograph on The Obstetric Forceps has just been issued by the Era Publishing Co. of this city.——Dr. Idella M. Grover has removed from Harvey, Ill., to Butte, Mont.; and Dr. S. B. Buchanan from Sioux City, Iowa, to Washington Boulevard, Chicago.